Best Practice

TOPICS IN REVIEW

Alcohol and substance abuse

see also p 227

Mr W, a 53-year-old Chinese man, was seen at the internal medicine clinic for recurrent lower leg pain, for which he requested analgesia.

A physical examination revealed hypertension and signs of chronic liver disease. When the primary care practitioner asked him about his use of alcohol and drugs, Mr Wu said that he consumed five to six drinks of whiskey at least 4 days per week.

Born in rural China, Mr W began drinking in his late teens and gradually increased his intake. By his mid-30s, he was drinking as much as half a liter of whiskey a day. He claims that there were no negative effects related to his alcohol consumption on his health or his work performance during that period. After arriving in New York City about 10 years previously, however, he had difficulty keeping a job. He complained that his jobs were exhausting and that he felt overwhelmed.

At the next consultation, Mr W reports that his actual intake of whiskey exceeds 750 ml (25 fl oz) daily. He says that he is drinking more because his boss is giving him a "hard time." Also, he states that he is unable to fall asleep without drinking alcohol. Mr W claims to be unaware that he physically and verbally abuses his wife and children while intoxicated, although he says he feels that he has lost status at home because he is not providing sufficient income.

Historically, alcohol has been an important ingredient in Chinese medicine. The Chinese written character for medicine/physician was partly constructed with the old character for wine. Chinese physicians were aware of the ill effects of alcohol, however. Records from as far back as the 21st century BC suggest that overindulgence in alcohol was viewed as evidence of character decay and immorality.

For all Asian groups, drinking patterns are influenced by cultural values related to family as the center of life, moderation, and self-restraint.[1] Despite these restraining influences, study results show that substance abuse is a substantial problem in the Asian American community, although its exact prevalence is unknown.

In the 1990s, Yoshida showed that many East Asians are heterozygous for the genes that are responsible for acetaldehyde dehydrogenase, the enzyme that metabolizes alcohol in the body.[2] When individuals who are heterozygous for this gene drink alcohol, they experience a buildup of serum acetaldehyde and facial flushing. As many as 70% of East Asians flush when drinking alcohol.[2] It is not known whether facial flushing confers protection from the effects of alcohol, nor whether continued drinking by those with facial flushing leads to more efficient processing of alcohol.

Summary points

- Although the exact prevalence of alcohol abuse in Asian Americans is unknown, results of studies suggest that it is an important clinical problem
- Patients should be screened for alcohol use with a culturally appropriate tool
- Recovery can begin when the patient and family recognize that there is a problem
- Key principles in treatment are maintaining a holistic "mind-body" approach and engaging the family in supporting the patient
- Asian patients tend not to accept 12-step programs because these programs have a confrontational style and involve public discussion of personal problems

PREVALENCE

In the 1993 National Household Survey, 21.7% of Asian American and Pacific Islanders had smoked cigarettes, 53.2% had used alcohol, 4.7% had used marijuana, and 1.4% had used cocaine in the previous year.[3] When compared to other ethnic groups, including whites, however, Asian Pacific Islanders had the lowest percentages of alcohol dependence (1.8%), need for drug treatment (1.7%), and heavy alcohol use (0.9%).[4,5]

Results of at least two studies show that Asian Americans use alcohol and other drugs as much as, if not more than, other minority groups, although their use is less than that of whites.[3,4]

As in other ethnic groups, Asian men drink significantly more than Asian women, although drinking by Asian women is more socially acceptable in America than in Asia. Cigarette smoking rates, conversely, are rising more rapidly among Asian women then among Asian men.[6]

Morbidity and mortality rates related to alcohol abuse are lower for Asian American men than for men in any other racial or ethnic group, and the lowest reported number of deaths from alcohol-related disease is in Chinese men.[7] Findings from studies of four Asian ethnic groups

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in California showed lifetime and heavy drinking rates were highest in Japanese Americans, followed by Chinese Americans and then Korean Americans.[4,8,9] Parrish reported high numbers of abstainers as well as heavy drinkers in Japanese American and Korean American groups.[8]

Southeast Asians living in the United States are reported to be at risk for alcohol problems because alcohol is readily accessible, the prevalence of depression and posttraumatic stress disorder is high, and they do not consider alcohol a harmful drug.[10]

Members of Asian Pacific Islander families rarely seek treatment for alcohol-related problems because they want to avoid the shame and disgrace accorded such problems within their traditions.[11] Individuals of Chinese, Japanese, Korean, and Filipino descent are underrepresented in alcohol and other drug treatment, and numbers of hospital admissions for alcohol-related problems in these populations are low.[12] The underrepresentation in treatment programs is believed to result in underestimation of alcohol problems in Asian communities.

In Asians, as in other ethnic groups, an association exists between alcoholism and other psychiatric disorders, particularly depression.

BARRIERS TO CARE

Not wishing to "lose face" in the community, family members may cover up a patient's alcohol or drug use by working harder (to replace lost income) and by rationalizing the patient's use as a consequence of health problems or job stress.

Often, Asian families make substance abuse the "family secret" and will not speak about it. They may even make it easier for the patient to access alcohol or drugs to avoid any physical or verbal abuse that might occur if the patient doesn't get a "fix."

Family members form close alliances with each other for support or comfort, leaving the addicted patient feeling helpless and isolated. If they eventually abandon the addicted patient after years of tolerating the substance abuse and its associated behaviors, they may themselves develop anxiety or depression, feeling sad and guilty about their inability to help the ill member.

Families may feel uneasy about discussing their problems with an "outsider," such as a counselor, social worker, nurse, or physician.

If patients cease their substance use, most Asian families view the problem as solved and do not understand the need for continued help and counseling.

ALCOHOLISM IN THE PRIMARY CARE SETTING

Because of the stigma associated with alcoholism, Asian Americans typically seek cures for specific physical symptoms, such as gastritis, rather than treatment for alcohol dependence itself. By being alert to the possibility of alcohol problems in their Asian patients, primary care practitioners can be the first to identify such problems.

Results of physical examinations (eg, signs of alcohol withdrawal/intoxication or chronic liver disease) and laboratory tests (eg, elevated γ-glutamyl transferase enzyme or increase in mean cell volume) during routine visits are early signs of alcohol abuse and its effects on the body.

The primary care practitioner has the opportunity to engage the patient and family in treatment of an addiction as a "physical illness," which is acceptable in Asian cultures, and still identify excessive alcohol use as the source of family, economic, and/or legal difficulties.

Culturally sensitive assessment

A culturally appropriate tool, translated into the Asian patient's native language or dialect, should be used when screening for alcohol abuse (see box 1).

If an alcohol problem is suspected, the practitioner should ask the patient and the family about the type and amount of beverages consumed, as well as the frequency of consumption. Drinking patterns in Asian and Asian American communities differ from those in the West. Many Asian patients do not drink every day. Drinking may occur only on the weekend or on days off from work. Binge drinking, defined as consumption of five or more drinks per occasion, is common in Asian patients, and assessing its effect on job function and family relationships may be difficult. Because performance of role obligations and duties is important in Asian cultures, Asian patients frequently report that drinking is not a problem as long as they continue to go to work every day and provide for their families.

Box 1 Screening tools for alcohol misuse

The AUDIT (Alcohol Use Disorders Identification Test)

- Developed by the World Health Organization and evaluated in six countries
- Used in several cultures, including Chinese and Japanese, with successful translation
- Has 10 questions on alcohol use (frequency of drinking, average consumption, and peak levels of intake), symptoms of alcohol dependence, and alcohol-related problems
- Is helpful in the early detection of alcohol problems in community and primary care settings

The CAGE questionnaire

- This tool is not appropriate for use in screening Asian Americans because it fails to detect problems other than frank alcoholism

Discussing the diagnosis

Because seeking treatment for a mental health problem outside the family represents a loss of face, patients confronted with a diagnosis of dependence will increase their resistance to treatment. Minimizing feelings of shame attached to the diagnosis will help patients to accept treatment.

Recognizing the strong belief of Asian cultures in the mind-body continuum, a valuable approach is to discuss the health status of the person in a holistic way and to emphasize physical as well as psychological health.

Treatment

Group treatment

Traditional treatment programs for alcoholism based on Alcoholics Anonymous (AA) and the 12-Step models are not readily accepted by Asian patients. These peer-based approaches must be modified to allow for Asian cultural beliefs. For example, Asians often find it difficult to disclose personal information in a group setting.[13]

The intervention of a trusted member of the Asian community, perhaps a clergyman or other cultural/community broker, can encourage a patient to participate in a group program. The trusted member can also reinforce to the patient the necessity of regular attendance.

The setting of the group treatment is an important consideration. If the group meets outside the community, the patient is likely to find few Asian Americans. If meetings are held within the patient's community, it may be difficult for the patient to remain anonymous. The close-knit nature of the community can reinforce a patient's reluctance to attend an AA meeting, where self-disclosure is expected.

Adam Hart-Davis/DHD Photo Gallery

Asian men consume more alcohol than Asian women, but Asian women have higher smoking rates than Asian men

Individual treatment

Treatment approaches that emphasize the individual, and the expression of an individual's needs and emotions, contradict the Asian emphasis on the mutual and interdependent needs of the family. Asian values stress the importance of the group's needs over individual needs and obligations and duties over rights and privileges.[12]

Asian patients and their families often view counseling as "chatting" instead of treatment. The Asian patient expects the health care practitioner to prescribe specific treatment for the illness or problems and to provide help with other social problems.[14] Therefore, counseling should be direct, but not confrontational, and should include immediate, practical solutions to concrete problems.

Training to improve language skills, acquire job skills, and learn ways to participate in the community enhances the patient's participation and success rate in substance abuse treatment programs.[9,14,15] Psychosocial approaches to treatment are best received when the approach is highly structured and the patient is informed by a respected person about the relationship between certain actions and their consequences.

Family counseling

Family counseling is an important management strategy for Asian patients who abuse alcohol. Educational and supportive approaches, rather than confrontational techniques, help families change patterns, such as codependency (the overt and covert ways that families enable the abuser to continue without change), that may emerge because of the strong traditions of interdependency. Family harmony and solidarity as well as subordination of individual goals for the sake of the family should be emphasized in relation to changing behavior.

Treatment planning

Whichever treatment is used, several principles in treatment planning are useful (see box 2). The primary care

Box 2 Principles of planning treatment for alcohol abuse

- Focus initially on engaging the patient and family in treatment and educating them about alcohol use and abuse
- Set as a realistic goal the reduction of alcohol use rather than abstinence
- Educate patients about the physical effects of alcohol to encourage them to seek treatment and to decrease denial (which is common in the initial stages of treatment)
- Be prepared for patients to say, "I work and take care of my family, I never get drunk, so how can I have a problem with alcohol?" Patients will also bargain about the acceptable amount of drinking as a way of avoiding treatment
- Use written guidelines and procedures for treating alcohol problems
- Give educational materials in the language or dialect of your patients
- Be supportive but authoritarian and directive. Authority increases credibility in the eyes of the Asian patient
- Use a problem-solving approach, based on the physical complaints and symptoms, which is effective in engaging and retaining Asian patients in alcohol treatment

provider should bear in mind that even brief interventions during a single visit can decrease alcohol consumption and adverse effects of use by as much as 20 to 50%.[16-18]

Inpatient versus outpatient treatment

Asian patients, especially those with family support, prefer outpatient treatment programs, including outpatient detoxification. A strong support network is important for success in such programs. An advantage of outpatient treatment is that patients may continue to work or attend school. Intensive outpatient treatment programs usually require a minimum of 9 hours attendance weekly. Patients must be motivated for treatment and have established a trusting relationship with their provider.

ABUSE OF OTHER SUBSTANCES IN ASIAN AMERICAN COMMUNITIES

Data on the prevalence of abuse of other substances in Asian Americans are limited. These data are summarized in box 3.

Box 3 Substances abused by Asian populations

Sedatives

- No prevalence data are available

  Clinical experience suggests that benzodiazepines and barbiturates are the sedatives abused most often
- Sedative herbs (eg, *Thuja Orientalis, Dioscorea Japonica*) may also be abused

Cocaine

- Abuse is uncommon but has been reported among acculturated Asian and Asian American youth who adopt American adolescent behaviors[6]

Marijuana

- Use among Japanese and Chinese Americans and Laotian, Vietnamese, and Thai immigrants in the United States is documented[19]
- About 1% of Asian Americans aged 12 to 65 use marijuana[20]
- Use may increase as a function of acculturation, socioeconomic factors, and education
- As with alcohol, the effects of chronic marijuana use (eg, apathy) may be more pronounced in Asian populations

Stimulants

- Methamphetamine use among Asian adolescents has been documented[20]
- Young Asian adults face pressures at home and in response to their image as the "model minority." Stimulants may be used to study or work longer
- Herbal medicines may also have a stimulant effect (eg, ginseng)

Nicotine

- Increasing prevalence of smoking in developing countries, especially in Asia, is mirrored in the behaviors of recent immigrants
- About 3% of Asians living in the United States report smoking one pack or more of cigarettes daily[21]
- A treatment approach for nicotine addiction is outlined in the Agency for Healthcare Research and Quality guidelines[22]

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